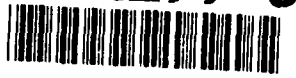

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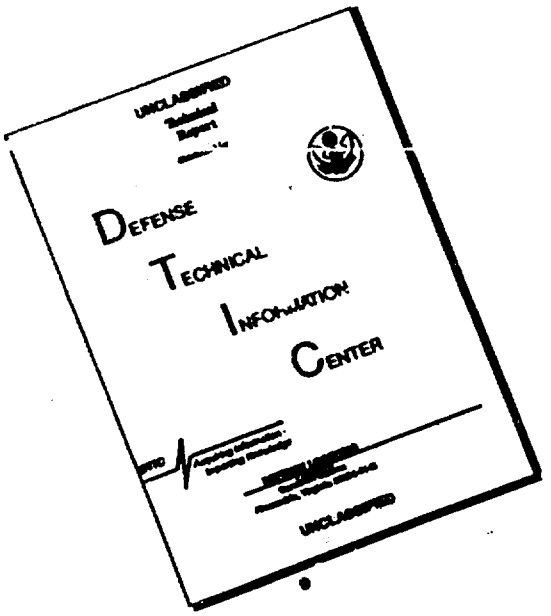

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Unquestionably, the IX international conference in Berlin June 7-11 was the largest of its kind. Some 15,000 participants, including 1500 members of the press corp, came together to review the struggle against HIV and AIDS. No break-throughs were announced and no startling discoveries seized the headlines. There was some sense of scientific advance in fighting opportunistic diseases and in understanding the life cycle and biology of HIV, but overall Berlin was a "business as usual" enterprise.

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Vol. 4 No. 4 July/August 1993

Inside Articles

SUPPLEMENT THIS ISSUE:

HIV/AIDS in the Global Military

Berlin Conference:
Struggling to Save 9.5 million Lives

STILL SEARCHING FOR A BLUEPRINT

Norman Miller*

By all accounts the global response to HIV/AIDS falls far short of the need. Too little is being done on prevention, on community-based care, on protecting and empowering women, and on reducing economic inequity that triggers large human migration to heavily infected areas. This was the central message at the IX International Conference on AIDS held June 7-11 in Berlin. Much of the debate focused on searching for elements in a global blueprint.

Answering his own question "what kind of a global response do we need; what can we achieve," Michael Merson, of WHO, estimated that 9.5 million lives could be saved before the year 2000 if a major effort at prevention is made.

"We must waste no time in scaling up those interventions that work. This means implementing , worldwide, a prevention package which should include the promotion and distribution of condoms; the treatment of conventional STDs because of their role in facilitating HIV transmission; AIDS education in schools and through the mass media; promotion of condom use by prostitutes and their clients; maintenance of a safe blood supply and needle exchange programmes for injecting drug users. ...The best mix of interventions must be adapted for the local context and adjusted to local constraints."

The search for a blueprint is in fact the search for many blueprints that respond to regional diversity. One of the key lessons from Berlin is that few, if any, generic behavioral solutions cut across cultures. Sexual behavior is conditioned by ethnicity, custom, language and social tradition.

The costs of prevention? Michael Merson calculates that a comprehensive prevention program in the developing world would cost some 2.5 billion (1990 dollars) a year. The compelling argument to find this money rests first on the incalculable importance of diminished human suffering. Further arguments center on the fact that the epidemic is increasingly striking the young, potentially the most productive members of their societies. A long term saving of some 90 billion, in direct and indirect costs, is also at stake by WHO calculations.

One figure the WHO did not provide is the costs of such prevention blueprints on an individual basis. If Mike Merson's calculations are at all accurate, the 9.5 million lives would be saved at a cost of $264 each.

WHO Estimates (June 1993)

HIV infected adults, worldwide	13,000,000
HIV infected children, worldwide	1,000,000
Total HIV infected	14,000, 000
AIDS cases, worldwide	2,500,000
Increase in AIDS cases in one year	500,000
Funds needed for prevention , per year	$2.5 billion

* Author's biographies on page 8.

Editor's Report

The Berlin Bazar

Unquestionably the IX international conference in Berlin June 7-11 was the largest of its kind. Some 15,000 participants, including 1500 members of the press corp, came together to review the struggle against HIV and AIDS. No break-throughs were announced and no startling discoveries seized the headlines. There was some sense of scientific advance in fighting opportunistic diseases and in understanding the life cycle and biology of HIV, but overall Berlin was a "business as usual" enterprise.

The meeting brought together an enormous assortment of interests including academic analysts and biomedical researchers, program managers, project directors, writers, and activists. Drug and pharmaceutical representatives, interest group managers, book exhibitors, and professional protestors combined to create the atmosphere of a gigantic bazar. Berlin gave us proof, if we needed it, that AIDS has become a very big business.

What were the new themes; what is the status of the key issues according to coverage in Berlin?

New Issues (very few) civil-military cooperation in HIV prevention; prevention policy criticism, issues surround hemophiliac transmission, long term survival issues.

Established issues gaining prominence: TB, gay and lesbian care, mandatory testing and quarantine, Aids in the work place, economic impact of *HIV/AIDS, spermicide with antiviral capacities to protect women*

Issues holding their own: Modeling and forecasting, womens' issues, vaccine development, geographic distribution and migration, risk in health care settings, drug use and HIV, mother-child transmission.

Declining issues: Human rights, care in developing countries, Haiti

There was a further sense in Berlin that the old messages, as tedious as they had become, still had to be underscored. "Condoms can be effective", "We must protect the teenagers", "Education is the only vaccine" were the repeated refrains of the struggle.

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NEWS DIGESTS

➨ ***India's Anti-AIDS Policies***
India's National AIDS Committee decided in March that, in the interest of protecting the confidentiality of HIV-infected people, AIDS will not be a notifiable disease. In order to deal with the shift toward drug injection (in Manipur, 54% of IDUs are found to be infected), the committee decided that the emphasis must be on prevention of drug injection rather than on needle-exchange programs. [*Lancet*, 341(8846); p. 684, 1993]

➨ ***Religious Politics in Spain Threaten Condom-promotion***
The high court in Spain declared illegal a government campaign for preventing STDs and unplanned pregnancies. There was strong opposition from religious groups to the condom-promotion slogan, stating it encouraged free sexual relations among youth. The court agreed that truth-in-advertising had been violated, noting that abstinence and mutual fidelity is the only way to completely eliminate STDs, and that condoms are not the safest method for preventing pregnancy. The ruling is likely to hinder subsequent condom-promotion campaigns. [*Lancet* 341(8848):817.]

➨ ***HIV and Breast Feeding in Developing Countries***
The anti-infective properties of breast milk appear to protect both HIV-infected and uninfected infants of HIV-infected mothers against gastrointestinal and respiratory illnesses. In addition, according to a study by the Italian National Registry of AIDS, breast-fed children who are HIV-positive have a slower progression to AIDS. However, given the estimated risk of transmission from a postnatally infected mother of 29%, WHO's advice to discourage HIV-1 infected women from breastfeeding where a safe alternative exists should be followed. [Mok J., *Lancet*, 341(8850); p. 930, 1993.]

➨ ***Canada's AIDS Strategy:***
The Minister of Canada's National Health and Welfare announced the 2nd phase of the Canadian National AIDS Strategy, highlighting the following directions:

- Enhancing partnerships, improving health promotion for people living with HIV/AIDS;
- Creating supportive social environments;
- Promoting and sustaining healthy behaviors;
- Recognizing HIV disease as a chronic and progressive disease.
- Emphasizing financial accountability and enhanced program evaluation.

Funding of $211 million was allocated over the next five years.

➨ ***Easing the transition for AIDS orphans***
The needs of AIDS orphans are being addressed by a number of social service agencies in the United States. The Families' and Children's AIDS Network in Chicago and the Child Welfare Administration of New York are two agencies that work to identify prospective foster and adoptive parents before children are orphaned by their parent's death from AIDS. With the assistance of supportive services, including legal counseling, the two families work together to ensure both an eased transition from family to family as well as the provision of a permanent home for the children. [*J. Amer. Med. Assoc.* Vol 269 (15) p. 1942; 1993]

NEWS BRIEFS

- **GAMBIA**: A study of the effects of post-test counseling on condom use among prostitutes in the Gambia found that overall, it had no effect. Scarce resources should be directed to providing condoms in bars rather than in providing counseling. [Pickering et al., *AIDS* 7(2);271. 1993]

- **JAPAN**: A citizen group in Osaka who helped organize a theme bar around AIDS prevention messages including "safe sex is hot sex" dismissed local criticism and said it would give 10% of the profits to people with HIV and AIDS. [*Japan Times* 14-3-93]

- **RUSSIA**: In April, President Boris Yeltsin approved the repeal of a law which made male homosexuality a crime, punishable by up to 5 years in prison. Epidemiologists and gay activists laud the repeal, stating that gays will now feel freer to be tested for HIV and request treatment. The number of anonymous sexual partners is also expected to decrease, now that openly gay relationships will not be deemed criminal activity.

- **TANZANIA**: The World Bank calculates the economy of Tanzania may be 25% smaller in 2010 than it would have been without AIDS. (Berlin Conference News, June 9, p. 2)

- **THAILAND**: The tourist industry is being adversely affected by anti-AIDS campaigns, and is asking that such campaigns be curtailed. Funding for prevention efforts is likely to be affected. [*Br. Med J.* 304(6837):1264. 1993]

- **US**: "HIV/AIDS will 'disappear,' not because, like smallpox, it has been eliminated, but because those who continue to be affected by it are socially invisible, beyond the sight and attention of the majority population." [National Research Council, *The Social Impact of AIDS., 1993*]

Berlin Quotes

"Are interventions effective in preventing HIV infections? Yes. Are current interventions having an impact on the epidemic? No!"

—Peter Lamptey, Family Health International

"It's time to stop doing what doesn't work. Accept that the best way to ger uninfected people to stay uninfected is to make them allies. Do not alienate them with coercion and threats of testing."

—Michael Merson, World Health Organization

New Ways of Cooperation

Anthropology and HIV/AIDS Prevention in Kenya

David O. Nyamwaya

Traditionally, anthropology has not been employed in programs aimed at changing human health behavior, since conventional anthropology usually requires long periods of fieldwork with analysis of collected data taking equally long periods. Such anthropology would not be relevant to HIV/AIDS education which requires approaches leading to fairly rapid cognitive and behavioral changes. In Africa, anthropology has been viewed with much suspicion by development workers because of its use in the pacification of various communities during the pre-Independence era. It is only recently that anthropology has entered the curricula of a number of universities in Eastern Africa. This introduction has led to a change of attitude about the discipline not only by the academicians but also by the development experts and workers.

Within the past 10 years, and more recently in response to the HIV/AIDS epidemic, anthropologists, clinicians and public health specialists have been working on the development of a condensed form of anthropology to improve the performance of health and nutrition programs. The condensed form of anthropology known as Rapid Assessment Procedures (RAP) involves the use of basic anthropological techniques such as informal and formal interviews, conversation, questionnaires, participant observation, and focus group discussions.

'The results are encouraging. The truckers' community can now discuss AIDS openly.'

The RAP techniques are used complementarily with a process known as triangulation, which involves the use of two or more methods to address a single research issue. Triangulation enables a RAP researcher to establish high levels of validity and reliability, both of which have proven elusive in conventional anthropology.

RAP was established in East Africa in 1989 during a workshop for researchers and health workers involved in AIDS prevention. A group of five social and health scientists based at the African Medical and Research Foundation (AMREF) participated in the training. The group has since developed a number of HIV/AIDS prevention activities using the RAP approach. One such an activity is the education for STD/AIDS prevention project for long distance truck drivers.

Research Using RAP: Truck Drivers

RAP has proven an effective tool for addressing STD/AIDS prevention among long distance truck drivers operating on the Mombasa-Nairobi-Uganda highway. Before implementing interventions, RAP was used to identify the social and cultural characteristics of the truck drivers. Using informal interviews, conversation and observations, AMREF discovered that the truck drivers, their assistants, petrol station attendants, commercial sex workers and restaurant and lodging workers along the highway comprised a closely knit sub-culture with normative attitudes and behavior.

The communication strategies were developed with much input from the truck-driver community. Informal interviews were used to discuss individual perceptions, fears, and concerns. Focus group discussion identified highly focused statements current in the community. Strategies used for promoting HIV/AIDS prevention were largely interpersonal. Peer educators received training regarding the messages, communication skills and record keeping. Focus group discussions were used to test messages before mass dissemination.

The initial investigation also determined that a number of factors, such as having sex with multiple partners, non-use of condoms, and self treatment for STDs, facilitated STD/HIV transmission. HIV/AIDS was regarded as an invisible disease, affecting foreigners and other strangers. Individuals regarded themselves safe from infection if they had sex only with people they knew. The disease was also believed to be harbored in thin/slim women; plump women were believed to be free of the disease.

Using RAP techniques and focus group discussions, a number of positive AIDS-prevention messages were developed and shared among members of the truck driver community. Messages instilling fear were sifted out. The messages included the need to use condoms, seek early treatment for STDs, and reduce the number of sexual partners. The latter was de-emphasized because of its lack of practicality; most members of the sub-culture are away from their regular spouses and therefore tend to engage in sex with other partners. In any case, the drivers tended to have several "regular" partners who were regarded not as prostitutes but as "wives."

The results are encouraging. The community can now discuss AIDS openly. Condom use has increased. Truck drivers and their associates seek early treatment for STDs. Communities within the various truck stop points and areas surrounding the stop points have started discussing and planning STD/AIDS prevention programs.

Conclusions

RAP, a condensed form of anthropology, is being used to address a specific sub-culture regarding STD/AIDS prevention. Originally, the project was to be targeted solely at the truck drivers; this focus was broadened because of the existence of a sub-culture involving people other than the drivers. The objective of the program was not just to give people information but to encourage behavior change. Anthropological techniques facilitated discussion on behavior change. Focus was placed on all members of a sub-culture, not just on the truck drivers.

The project used non-medical people to plan and implement a program. Clinicians were involved in the determination of

turn to page 8

HIV/AIDS Prevention in Africa Lessons and Legacies from the HAPA Grants Program

The HAPA Grants Program

Nearly 70% of the people in the world infected with HIV, the virus that causes AIDS, live in sub-Saharan Africa. In May 1993, it was estimated that over eight million people in this region were HIV positive. Slowing the spread of HIV/AIDS in Africa has proven to be a complex undertaking. Changing behavior, which remains the major option for HIV prevention, is extremely difficult. It is clear that all sectors of society, including both governments and nongovernmental organizations (NGOs), must be involved in developing responses to the crisis. NGOs have demonstrated ample experience in carrying out health and development programs at the community level; a critically important component of strategies aimed at slowing the spread of this infection, therefore, involves enlisting NGOs in the response to the global pandemic.

From 1989 through 1992, the HIV/AIDS Prevention in Africa (HAPA) project of the Bureau for Africa, United States Agency for International Development (A.I.D.), provided grants to five U.S.-based private voluntary non-governmental organizations (PVOs), and one university, to conduct nine HIV/AIDS prevention projects in sub-Saharan Africa. The projects were: Save the Children, in Zimbabwe and Cameroon; World Vision Relief and Development, in Zimbabwe and Kenya; CARE, in Rwanda; Project HOPE, in Malawi and Swaziland; World Learning (founded as the Experiment in International Living) in Uganda; and The Johns Hopkins University School of Hygiene and Public Health, Department of Epidemiology, in Malawi. Grant recipients focused their projects on education and motivation for behavior change, integrating those activities into ongoing health and development programs. The grants were meant to provide "seed money" to help the recipient groups establish technical expertise in HIV/AIDS prevention.

The HAPA Support Program

The HAPA grants program was one of A.I.D.'s first efforts at large-scale funding of NGOs to undertake HIV/AIDS prevention. A technical support component, established at The Johns Hopkins School of Hygiene and Public Health, was seen as an important element of the Africa Bureau's approach, since it providing a link between A.I.D. and the PVO projects that would otherwise have been difficult to maintain.

The primary role of the HAPA Support Program was to assist the HAPA grantees in the development, implementation, monitoring and evaluation of appropriate and effective community-based intervention strategies for HIV/AIDS prevention. In addition, regional African workshops enabled the HAPA Support Program to facilitate communication between HAPA grantees and other organizations working on HIV/AIDS prevention. A technical advisory group reviewed project reports and provided guidance to the Support Program on the development of technical standards for the projects.

Lessons Learned from the HAPA Grants Program

The HAPA experience demonstrated that many diverse program skills are required to develop and implement effective HIV/AIDS prevention activities. The following recommendations are presented to assist PVOs, NGOs, and their funders to most effectively respond to the HIV/AIDS pandemic.

1. **A technical support component is an important part of any HIV/AIDS grants program for NGOs or PVOs.** The specialized expertise required in the response to HIV/AIDS often goes beyond individual PVO and NGO capacity. This situation is due less to limitations

of these organizations than to the overwhelming demands of the task of responding to HIV/AIDS, and the relative lack of international experience and effective models dealing with the problem. Functions of a technical support program for HIV/AIDS prevention projects should include at least the following:

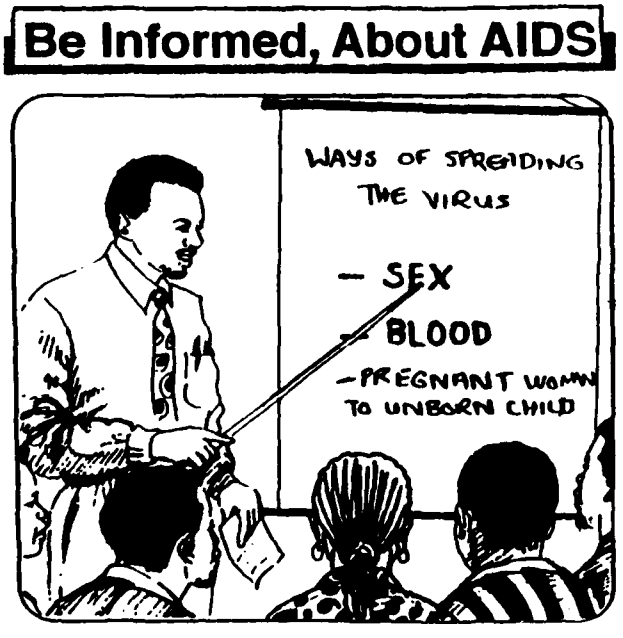
a. **Serving as a technical resource** to the projects by arranging or providing individual technical assistance. In addition, a technical support program should review, condense and make available useful current findings in HIV/AIDS research and programs, and communicate this information to the field projects.

b. **Facilitating networking and communication** of project staff with other projects and individuals working on similar prevention programs. Maintaining contact with others involved in the response to HIV/AIDS is one of the most important ways that PVO staff can both learn how to maximize the effectiveness of their activities and maintain morale. Regional workshops can be an extremely valuable mechanism to facilitate communication.

c. **Providing intensive guidance in the development of project interventions** very early in project life. Important aspects of the guidance process are for support program staff to 1) develop rapport and trust with field staff, 2) use interactive, participatory approaches to become familiar with the aims, needs and constraints of the project, and 3) work with staff to identify the need for changes or modifications.

d. **Providing special assistance with monitoring and evaluation.** Issues related to levels and types of objectives and indicators expected by the grants program need to be discussed and clarified at the outset. Although specific decisions may depend on the overall purpose of the grants program, the HAPA experience indicated that process and output evaluation should be stressed, since they represent a realistic level of monitoring for most PVOs and NGOs.

e. **Training staff in the gathering and use of qualitative and quantitative data to assist with planning and evaluation.** This is an important area of technical assistance that needs special emphasis in most new HIV/AIDS projects. PVOs planning HIV/AIDS activities need to use both qualitative and quantitative methods of gathering information about the populations they plan to reach.



Source: Brochure, The AIDS Information and Support Centre (TASC), sponsored by Project HOPE/Swaziland HAPA project

2. **PVO/NGO projects responding to HIV/AIDS are likely to require more individualized external technical assistance than might be anticipated based on experience with other health and development programs.** The sexual transmission of HIV is a sensitive topic that may necessitate special training for project staff to help them become comfortable with discussing issues related to sexuality. The development of skills such as counseling, producing effective educational materials, and monitoring and evaluation of these new activities may require specialized assistance often not available within the organizations.

3. **A PVO/NGO grants program should develop technical reporting requirements in collaboration with the grantees.** The grants program should clearly justify the purposes of any required reports, and provide specific, timely feedback on all reports that are submitted.

4. **A technical advisory group (TAG) for PVO/NGO grants programs is potentially very useful.** The TAG should be composed of re-

spected and technically competent individuals who are able and willing to take an active role in assisting the support program to provide oversight of the projects and technical reviews of project reports. Diversity of disciplines, experience, and affiliations of TAG members is highly recommended.

5. **Lessons learned in the course of a grants program should be shared on an ongoing basis.** Some of the key programmatic lessons learned through the HAPA field projects include:

   a. **Projects responding to HIV/AIDS should confine their initial efforts to a limited number of interventions, target groups and geographic settings.** Attempting to do too much too quickly often results in inadequate planning, monitoring and followup of project activities.

   b. **Training staff and volunteers to carry out AIDS education or counseling is a critical step towards project implementation; however, both the process and expected results of the training need careful definition and followup.** Staff should train only as many volunteers as can regularly be supervised, and plan as lengthy an initial training as circumstances will afford, to be supplemented by regular refresher sessions thereafter.

   c. **PVOs must be prepared to help clients meet the needs that their educational efforts may generate.** Examples of such needs that are likely to arise from successful education efforts are condom distribution, HIV testing, STD services, counseling, and supportive care for persons with AIDS. Although most PVOs will not be able to respond to all of these needs dire , they must be aware of resources that are available to their project populations.

   d. **Expectations for sustainability must be carefully defined.** In most cases, it is not realistic to expect that projects responding to HIV/AIDS will become financially self-supporting without additional external inputs. Other indicators of sustainability relevant for projects responding to HIV/AIDS are the extent to which local understanding, skills and commitment to continue project activities are built up, and the increased linkages that are made with community groups and national organizations. Projects of less than three years duration are not recommended because of the substantial time required for planning, implementing and evaluating a new area of effort.

   e. **International PVOs should be encouraged to have active and formal links with indigenous organizations,** whether they be NGOs or an appropriate unit within local or national government. Such linkages are not

Source: Kenya Office of World Vision International

A Maasai mother and child

easily developed or maintained, but represent an important component of any PVO project's sustainability strategy. The specific nature of the collaboration needs to be carefully and jointly defined very early in its development.

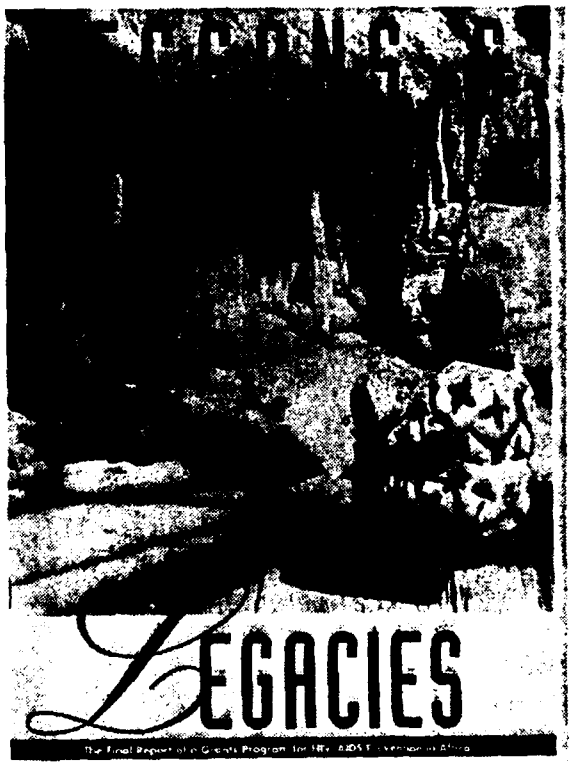
   f. **HIV/AIDS projects need to consider carefully the most effective ways that target groups can participate in the design and implementation of activities.** Identifying and involving influential community leaders

is a critical first step towards assuring community participation, whether the "community" is composed of urban slum dwellers, family planning clinic attendees, clients of commercial sex workers or rural populations. NGOs, together with the community, need to identify the unique needs of each group, as well as the contribution that each group can make to an overall approach to controlling the pandemic.

g. **All AIDS projects working at the community level must understand and address the local social and cultural context of HIV and AIDS,** and must develop their messages about transmission and prevention in relation to this context. Two especially important issues for community-based projects to consider in their programs are the perception that AIDS is a moral as well as a health issue, and the existence of imbalances in gender-based power relations, heavily influenced by socioeconomic conditions, that largely determine the effectiveness of efforts to prevent heterosexual transmission of HIV.

Making use of the lessons of HAPA

In practical terms, the usefulness of the lessons learned from the HAPA grants will lie in the extent to which those lessons, however tentative, are implemented. A recurring theme of the contributions from each of the participants in the HAPA grants program - field, headquarters, advisory and support program staff—was the need to further strengthen non-governmental efforts to respond to the HIV/AIDS pandemic. Future containment of the AIDS crisis will involve enabling communities to harness their energy and commitment, and direct it towards finding and implementing their own solutions to the problem. An important role of NGOs and PVOs is to provide mechanisms for supporting community mobilization in response to the HIV/AIDS pandemic.



For a copy of the full report, ***Lessons & Legacies:* The Final Report of a Grants Program for HIV/AIDS Prevention in Africa** by Mary Anne Mercer, Cynthia E. Mariel and Sally J. Scott, please contact:

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Commentary

AIDS/HIV Counseling in the Developing World

Donald H. Balmer

As we enter the second decade of the AIDS pandemic, the political, legal, cultural, ethnic, and economic facets of AIDS become increasingly apparent. The dichotomy between developments of the pandemic in the developed and the developing world is apparent in the realm of HIV counseling and testing.

The practice of HIV counseling in the developed world relies upon the WHO/GPA model of pre-and post-test counseling. This model, addressing the stigma associated with the modes of HIV transmission, responds to the personal risk of being HIV tested by employing 'informed consent.' Individuals are given basic information during pre-test counseling, whereupon they decide for themselves (i.e.,'informed consent') whether or not to be tested.

The practice of 'informed consent' was similarly applied in the developing world. However, the same social consequences do not necessarily apply in the developing world, and there is no reason to suppose that AIDS *per se* confers the same personal risk. Consequently, while pre-test counseling works well in the developed world, it has not been so effective in the developing world.

The reasons for this are varied. Whereas in the developed world, a pharmacological response to the virus is possible, offering incentive to be tested and subsequently treated, the developing world has no such pharmacologic opportunities, and as a result, there is less imperative to discover one's HIV status. Other factors contribute to the fact that relatively few return for their test results or benefit from the valuable education conferred during post-test counseling. The tendency to delay counseling and testing until symptoms appear results in "confirmed" fears by virtue of pre-test counseling alone. The cost and inconvenience of transportation to medical centers, where test results are usually given, contributes to the lack of follow-up.

The Network of AIDS Researchers in Eastern and Southern Africa (NARESA) has devised a new counseling model, using an eclectic and integrated approach, which can respond to the full range of economic and social problems found in the developing world. A training program was designed, and the first cohort of 12 counselor-trainers was trained over a one month period at NARESA's Centre in Nairobi. Participants learned through an interactive model, allowing them to explore their own subjective experiences. Individual behavior and group dynamics served as the basis for investigating the theoretical foundation. Counseling skills, selected so that counselors can achieve therapeutic outcomes with all clients, were explored and practiced in small groups. Interactions were videotaped so that participants could observe and analyze their behavior. These counselor-trainers have now returned to their countries to organize counseling courses, based upon this model and guided by a cross-cultural counseling manual.

Counseling is one of the few therapeutic interventions which is affordable and feasible for developing countries. The NARESA initiative will establish a network of counselors who will collaborate in a comprehensive evaluation of this eclectic model for the developing world. The results of this evaluation will be available in the future. ❑

Report from Italy

Injecting Drug Use and AIDS

Giovanni Rezza

Compared to other European countries, Italy has the highest proportion of injecting drug users (IDUs) among AIDS cases, and like Spain, exhibits the so called "Mediterranean pattern" of the HIV epidemic. HIV prevalence among IDUs is relatively high: approximately 30% of IDUs attending drug-treatment centers are infected. However, prevalence ranges from less than 10% in some areas of southern Italy to over 50% in Milan and other areas of the north. The mean age of IDUs attending drug treatment centers for heroin use is approximately 27 years, with a male to female ratio about 4:1. Female IDUs are, however, more likely to be infected than male IDUs, possibly due to sexual transmission. Several studies have demonstrated that both HIV prevalence and incidence is higher among females.

An interesting phenomenon recently observed in Rome is the influx of drug users from developing countries, particularly South America and North Africa. There is only one methadone treatment center in Rome authorized for non-Italian IDUs. Most of the South American IDUs frequenting this center are Brazilian, of whom the majority are transvestite sex workers. Most used both heroin and cocaine and began injecting drugs while in Italy (drug use in Brazil is mainly restricted to non-injected drugs). Approximately 70% of the Brazilian IDUs who agreed to undergo HIV serological testing were found seropositive.

North Africans constitute another group of non-Italian IDUs attending the treatment center in Rome. Most started using and/or injecting drugs while in Italy, often as a consequence of involvement in drug trafficking. Prevalence of HIV infection (approximately 10%) among a number of North African IDUs who were tested in Rome was lower than that of Italian IDUs. Outreach programs should be implemented in order to contact these difficult-to-reach groups and to give them proper information on AIDS.

The Italian Ministry of Health has made a great effort in the past four years to launch mass media national information

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Vaccine Watch

David Heymann

Preparing for HIV Vaccine Trials: Activities of the World Health Organization

In the January 1993 issue of AIDS & Society, *Dr. Donald Burke discussed considerations about the design of a large scale trial to assess the efficacy of an HIV candidate vaccine in preventing HIV infection, and identified a number of scientific, ethical and logistical challenges which would need to be met. For this issue* AIDS & Society *has invited a guest columnist, Dr. David Heymann to report on vaccine development initiatives at WHO.*

The Global Programme on AIDS of the World Health Organization has conducted a series of consultations and meetings with international experts in HIV vaccine development which have considered many of the scientific, ethical, and logistical issues. Based on the expert advice obtained, WHO has developed a strategy for HIV vaccine development which includes (a) promoting the development of HIV vaccines which are appropriate for use in all parts of the world, including developing countries; (b) facilitating field evaluation of candidate HIV vaccines under the highest technical and ethical standards; and (c) ensuring the worldwide availability of those vaccines which are shown to be safe and effective.

Promotion of appropriate HIV vaccines

Appropriate HIV vaccines should induce long-lasting immunity with as few doses as possible; protect against antigenically different HIV strains circulating in different parts of the world, including developing countries; and be easy to administer, thermostable and affordable. WHO encourages vaccine manufacturers to explore new avenues for the development of appropriate HIV vaccines, and has established a WHO Network for HIV Isolation and Characterization which systematically isolates and characterizes HIV strains from developing countries in different parts of the world. Information and strains/reagents from this Network are provided to HIV vaccine manufacturers in order that existing candidate HIV vaccines may be tested against these strains and new candidate vaccines developed which may be more appropriate for developing countries.

Facilitation of field evaluation of candidate HIV vaccines

Four countries (Brazil, Rwanda, Thailand, and Uganda) have been selected by the GPA Steering Committee on Vaccine Development from among 14 countries which were assessed after having expressed an interest in close collaboration with WHO in the global effort of HIV vaccine development. Each of these countries has prepared a national plan for HIV vaccine development and evaluation which has been officially approved by WHO, and which provides a blueprint of national activities to prepare for HIV vaccine efficacy trials. Activities supported under these plans include virus isolation and characterization (as part of the WHO Network); establishment of HIV seronegative cohorts of persons at high risk of HIV infection in which safe sex and other prevention interventions are implemented to better understand their impact on HIV incidence during an eventual HIV vaccine trial; phase I/II trials of HIV candidate vaccines to further assess their immunogenicity in different populations; social and behavioral research in issues pertinent to HIV vaccine trials such as clear understanding and informed consent; and strengthening/development of information channels for better understanding about HIV vaccine trials among all levels of the local and national populations.

Ensuring worldwide availability

WHO is keenly aware of the importance of planning now for making safe and effective HIV vaccines available worldwide in the future. In addition to drawing from the lessons learned by WHO immunization programmes such as the Expanded Programme on Immunizations, WHO maintains continuous formal and informal dialogue with manufacturers of candidate HIV vaccines to explore innovative mechanisms which could be used to make HIV vaccine widely available. ❑

Injecting Drug Use and AIDS

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Rezza

campaigns. However, only a few pragmatic risk reduction programs addressing IDUs have been implemented. Syringes are easily obtained from pharmacies and vending machines, which have been provided in various cities by private companies and non governmental organizations. However, there are no needle exchange programs, and the restrictive policy towards methadone maintenance programs still remains.

In 1990, the Italian Parliament approved an "AIDS law" which emphasizes confidentiality of information and anonymity regarding HIV testing. The Italian Government has always supported the European Community's resolutions against discrimination of people with HIV/AIDS, including travel restrictions. However, a debate regarding mandatory HIV screening -particularly for prisoners- has recently surfaced. ❑

Call to Delay Release of Vaccine

Citing the vast disparity between developed and developing countries' ability to respond to the current AIDS crisis, the late Jon Gates, former coordinator of the Inter-Agency Coalition on AIDS and Development, called for a global display of solidarity of people with HIV and AIDS. He encouraged individuals to call upon governments and multinational organizations to delay the release of any AIDS vaccine until it is affordable and accessible worldwide. "We would send a powerful message to people living with HIV and AIDS in developing countries that we will not allow the lifeboat to leave until we are assured that everyone will be on board," he said in a speech given to the Canadian AIDS Society in Halifax last May. Mr. Gates died in December of an AIDS-related illness. [*Toronto Globe* 12/15/92.] ❑

Recent Publications

ARTICLES

- Evans BG, Catchpole MA, Heptonstall J, et al. "STD and HIV infection among homosexual men in England and Wales." *British Medical Journal* 306(6875): 1993.
- Fox LJ, Bailey PE, Kazu L, et al. "Condom use among high-risk women in Honduras: evaluation on an AIDS prevention program." *AIDS Education and Prevention* 5 (1); 1-10: 1993.
- Pison G, LeGueno B, Lagarde E, et al. "Seasonal migration: a risk factor for HIV infection in rural Senegal." *J. Acquired Immune Deficiency Syndromes* 6:196-200: 1993.
- Prazuck T, Tall F, Nacro B, et al. "HIV infection and severe malnutrition: a clinical and epidemiological study in Burkina Faso." *AIDS* 7;103-108: 1993.
- Smith HL., "On the limited utility of KAP-style survey data in the practical epidemiology of AIDS, with reference to the AIDS epidemic in Chile." *Health Transition Review* 3(1); 1-16: 1993.
- Van dePierre P, Simonon A, Hitimana DG, et al. "Infective and anti-infective properties of breastmilk from HIV-1-infected women." *The Lancet* 341

BOOKS

- Berer M & Ray S, eds. *Women and HIV/AIDS: An International Resource Book.* 400pp. London: Pandora Press. 1993. Available in English, French, or Spanish. £5.50 plus postage for developing countries; £14.99 for orders from Europe, North America, and Australia/New Zealand. Contact: Marge Berer, 1 London Bridge St, London SE1 9SG, UK; Tel: 44 71 357 0136; FAX: 44 71 357 0137.
- Bor R, Miller R, Goldman E. *Theory and Practice of HIV Counselling: A Systemic Approach.* 204 pp. New York: Brunner/Mazel Publishers. 1993. US $21..95. Tel: (212) 924-3344; FAX: (212) 242-6339.
- Diamant L., ed. *Homosexual Issues in the Workplace.* 268pp. Washington DC: Taylor & Francis. 1993. Address: Taylor & Francis 1101 Vermont Ave NW, Suite 200, Washington, DC 20005-3521. FAX: (202) 289-3665.
- Fuenzalida-Puelma H, Parada AML, LaVetu DS, eds. *Ethics and Law in the Study of AIDS.* 273 pp. Washington, DC: Pan American Health Organization, 1992. US $26.00.
- Kirp DL, Bayer R, eds. *AIDS in the Industrialized Democracies: Passions, Politics, and Policies.* 393 pp; New Brunswick, NJ: Rutgers University Press. 1992.
- Knox EG, MacArthur C, Simon KJ. *Sexual Behavior and AIDS in Britain.* London: HM Stationery Office. 1993.
- National Research Council: Jonson AR & Stryker J, Eds, *The Social Impact of AIDS in the United States.* 336pp; Washington DC: National Academy Press. 1993. US $34.95 in US, Mexico, Canada; US $42.00 Export. National Academy Press 2101 Constitution Ave NW, Box 285, Washington DC 20055. Tel: (202) 331-3313.

OTHER RESOURCES

- *Help Stop AIDS* is a booklet in cartoon form targeting young children and teens. Represents a Christian perspective. Available in English and Kiswahili. Contact: Africa's Children, PO Box 46328, Nairobi, Kenya.
- WHO Guidelines for Home Based Care. Contact: Global Programme on AIDS, World Health Organization, 1211 Geneva 27, Switzerland.

AIDS Networks

CDC HIV/AIDS Prevention Newsletter. Published by the US Department of Health and Human Services and Centers for Disease Control and Prevention (CDC), this quarterly covers national HIV/AIDS education and prevention programs, reports on relevent social and behavioral issues, and makes note of pertinent resources and funding opportunities. Internationally, the CDC collaborates with the World Health Organization, the Pan American Health Organization, and the US Agency for International Development to provide both short- and long-term technical assistance and training to countries most affected by HIV/AIDS. Contact: CDC HIV/AIDS Prevention Newsletter, 1600 Clifton Road, MS/E-41, Atlanta, GA 30333, USA.

Network is a bulletin published by Family Health International which covers topics on reproductive health, including contraception, adolescent fertility, STDs, and AIDS. Volume 13(4) of May 1993 covers Women and AIDS as well as an analysis of AIDS; The Second Decade. It is available in English, Spanish and French, and distributed without charge. Contact: FHI, PO Box 13950, Research Triangle Park, NC 27709, USA. FAX: (919) 544-7261.

- **Cross S, Whiteside A, eds. *Facing up to AIDS: The Socio-Economic Impact in Southern Africa.* 290pp. Hampshire, England: Macmillan Press. 1993. £ 40.00 (Hardcover), £ 13.99 (Paperback).**

In this text, economists, demographers and health planners present a range of new methods of understanding the likely course of the HIV/AIDS, drawn from the most recent research and thinking by social scientists on the relationship between epidemic disease, economic growth and human resources.

- **Ulin PR, Cayemittes M, Metellus E., *Haitian Women's Role in Sexual Decision-making: The Gap Between AIDS Knowledge and Behavior Change.* 95pp; AIDSTECH, FHI, Research Triangle Park, Durham, NC, USA.**

The results of a qualitative study using the focus group method point to an urgent need to intervene on behavioral expectations. Existing beliefs deny most Haitian women the right to protect themselves and their families from HIV/AIDS. Includes recommendations and implications for planning and applied research.

Author's Biographies

Don H. Balmer is Senior Lecturer in Psychology at the University of Nairobi, Kenya, and worked as consultant for NARESA's cross-cultural HIV counseling initiative.

David Heymann, MD, is Director of Research, Global Programme on AIDS, World Health Organization, Geneva.

Norman Miller, PhD, is on the faculty of Dartmouth Medical School and editor of *AIDS & Society.*

David O. Nyamwaya, PhD, is director of Health Behaviour and Education Department, and Coordinator, AIDS Programme, African Medical and Research Foundation.

Giovanni Rezzi is a member of the International Advisory board of *AIDS & Society* and Director of Research, Laboratory of Epidemiology and Biostatistics Advanced Institute of Health, Ministry of Health, Government of Italy.

HIV/AIDS Prevention in Kenya

from page 4 **Nyamwaya**

content. The interpersonal strategies used enabled program implementors to break the embargo on discussions on STD/AIDS. Print and audio materials were used peripherally to reinforce messages.

Originally starting as an operations research project funded by FHI/AIDSTECH, the program is now speading to cover most of the major truck routes in Kenya. In neighboring Tanzania, a more extensive program is well underway.

Further readings:

1. Denzin N., *The Research Act: A Theoretical Introduction to Methods, 2nd Ed.* McGraw Hill: New York. 1978. 2. Maticka-Tyndale E., "Triangulation of methods in health research." Paper presented at the 1st National Conference on Health Promotion Research, Toronto Ontario. 1990. 3. Scrimshaw SCM. and H. Hurtado. *RAP—Rapid Assessment Procedures for Nutrition and Primary Health Care: Anthropological Approaches to Improving Programme Effectiveness.* United Nations University: Tokyo. UNICEF/United Nations Children's Fund. UCLA Latin American Centre. 1987.

Conference Calendar

July 19-August 13
United Kingdom

Planning for AIDS and HIV in Developing Countries: A Study Workshop for Professionals
Contact: The Course Coordinator, Overseas Development Group, University of East Anglia, Norwich NR4 7TJ, UK. Tel: (0603) 57880, FAX: (0603) 505262.

September 7-10, 1993
Edinburgh, Scotland.

2nd International Conference on HIV in Children and Mothers
Contact: Conference Secretariat, Index Communication, Index House, 19 The Hundred, Romsey Hampshire SO51 8GD, UK Tel: (+44) 794 511331; FAX: (+44) 794 511455

September 13-24

2nd International Conference on STDs in Developing Countries
London School of Hygiene and Tropical Medicine Intended for AIDS and STD control program managers in the developing world. Contact: Dr. Margaret A. Parker, Ass't Registrar, Short Courses Registry, LSHTM, Keppel St, London WC1E 7HT. Tel: (44 71) 927 2074. Fax: (44 71) 323 0638.

October 31-Nov 3
Century Plaza Hotel
Los Angeles, CA

Association of Nurses on AIDS Care 6th Annual Conference
Contact: Exhibit Manager, ANAC, Suite 106, 704 Stony Hill Rd, Yardley, PA 19067. Tel: (215) 321-2371; FAX: (215) 321-2370.

November 4-7, 1993
Hyatt Regency Hotel
Chicago, Illinois, USA

36th Annual Meeting of The Society for the Scientific Study of Sex
Contact:, Howard J. Ruppel, Jr., M.A., Executive Director, SSSS, PO Box 208, Mount Vernon, IA 52314, USA, Tel: (319) 895-8407, Fax: (319) 895-6203

November 13-17
Chicago, Illinois

7th International Conference on AIDS Education for the International Society for AIDS Education. ***Diversity on Common Ground: Bridging Research and Practice.***
Contact: ISAE Executive Office, University of South Carolina School of Public Health, Columbia, SC 29208, Tel: (803) 777-6217, Fax: (803) 777-4783.

November 13-21
Kampala, Uganda.

All Africa AIDS and the Church Consultation
Co-sponsored by the Association of Evangelicals of Africa and Madagascar and MAP International.
Contact: MAP International PO Box 21683, Nairobi, Kenya

November 29-Dec 3,
Nairobi, Kenya

1st Congress of Near East and Africa Region of the Medical Women's International Association: "The Health of Women and Safe Motherhood."
The Chairperson, Congress Organising Committee, PO Box 49877, Nairobi, Kenya. Tel/Fax: (254 2) 56 08 13.

December 12-17, 1993
Palais des Congres
Marrakech, Morocco

VIII International Conference on AIDS in Africa
Contact: Société Africaine Anti-SIDA, Secretariat de la Conference, 1 Place Charles, Nicolle, Casablanca, Morocco, Tel: 20 01 04; FAX: 26 09 57

August 7-12, 1994
Yokohama, Japan

10th International Conference on AIDS/International Conference on STD
Contact: Congress Corporation, Namiki Bldg., 5-3 Kamiyama-cho, Shibuya-ku, Tokyo 150, Japan. Tel: 81 3 3466 5812; FAX: 81 3 3466 5929.

AIDS & SOCIETY

SUPPLEMENT

INTERNATIONAL RESEARCH AND POLICY BULLETIN

Vol. 4 No. 4 July/August 1993

Inside Articles

This Issue:

A special supplement based on the first international seminar on HIV/AIDS in Military Populations Around the Globe.

—Berlin, Germany
June 1993

International Security Issue?

HIV/AIDS in the Global Military

Will AIDS destabilize some countries and lead to regional conflict? Is the high incidence of HIV in many third world militaries a harbinger of political disruption? Concern about HIV in military units has surfaced as more countries reveal the extent of military HIV. Rates today in many armies of the developing world, particularly Africa, are over 65% of all military personnel. Officers in some flying units and armoured units are reported to be 100% seropositive.

Several factors make the global pandemic a significant international security issue as well as an imposing research and clinical challenge. Unquestionably, the ultimate impact of HIV/AIDS extends well beyond its mortality toll as a viral epidemic. One such cost is the destablization caused by loss of trained and experienced personnel, both military and civilian. Other social factors that can have an impact on military stability include the deflection of scarce resources from military budgets, the strain on limited public health and educational systems, the reduction of economic productivity, the reduction of the work force and the reduction of healthy recruits from the national conscription pool.

More specifically, militaries have unique problems concerning HIV/AIDS. First, the military has the responsibility to defend the nation and its interests against harmful forces or unwanted outside intervention. When the military is weakened as a result of an infection such as HIV, so is the defensive posture of that country.

Second, the military is concerned about transmission of infection within its

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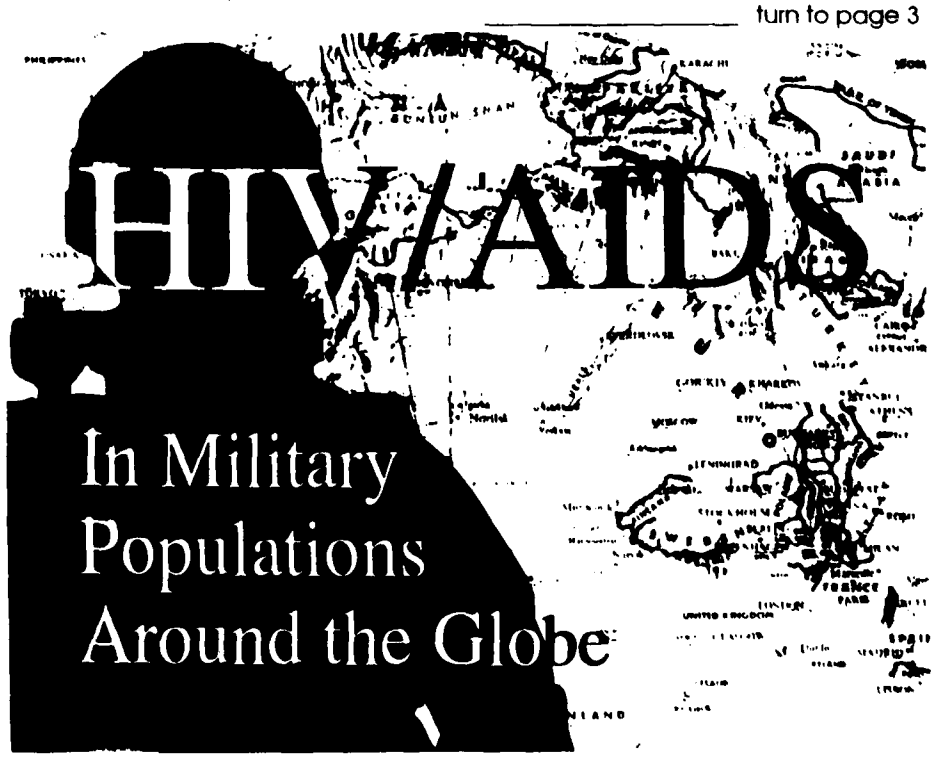

CONSENSUS STATEMENT

MILITARY AND CIVILIAN COOPERATION IN RESPONSE TO THE HIV AND AIDS EPIDEMIC

WHEREAS the world now faces a disastrous global epidemic of HIV and AIDS;

Whereas HIV recognizes no boundaries and knows no sovereignty;

Whereas military communities are at risk for HIV and AIDS;

Whereas the HIV and AIDS epidemic is both a serious public health problem and a threat to social and economic development;

Whereas the HIV and AIDS epidemic in many parts of the world poses a potential threat to political stability and national security, and is a potential hindrance to peace.

RECOGNIZING the critical role of a unified, effective, and sustainable national response to the epidemic;

Recognizing further that effective and sustainable HIV and AIDS prevention and care policies and programs demand close cooperation between military organizations and local, national, and international civilian organizations.

WE HEREBY URGE that military organizations around the world:

Immediately cooperate to combat HIV and AIDS as a common threat;

Share lessons learned in the effort to develop effective sustainable prevention and care policies and programs;

Ensure that persons with HIV and AIDS are always treated with dignity;

Provide compassionate health care and social support for persons with HIV and AIDS;

Strive to dispel irrational fears about HIV and AIDS in the military environment;

Recognize their capacity for care and prevention in both military and civilian communities; and

Participate in global HIV and AIDS research.

WE COMMIT ourselves to the fostering of a spirit of cooperation and the sharing of experiences between military organizations and the communities in which they live and work in our common struggle against the HIV epidemic.

This statement was adopted by participants at the Seminar on HIV/AIDS in Military Populations Around the Globe, Berlin Germany, 6 June, 1993. Participants came from ministries of defense, military health organizations, national HIV and AIDS programs, multi-lateral, bilateral and non-governmental organizations and academic institutions. They were drawn from:

- Australia
- Belgium
- Brazil
- Canada
- Congo
- France
- Germany
- Greece
- Indonesia
- Italy
- Kenya
- Korea
- Morocco
- Netherlands
- Norway
- Peru
- Philippines
- Portugal
- Russia
- Rwanda
- Senegal
- Switzerland
- Thailand
- Turkey
- Uganda
- United Kingdom
- United States
- Zimbabwe

The Seminar was sponsored by the United Nations Development Programme (UNDP) and the Walter Reed Army Institute of Research (USA) and was facilitated by *AIDS AND SOCIETY: The International Research and Policy Bulletin.*

First Global Meeting

Berlin Military AIDS Seminar

In a first-ever meeting, military and civilian leaders from 28 nations met in Berlin Germany June 6-7 for a policy seminar on HIV/AIDS in Military Populations Around the Globe.

Results of the seminar include:

•Conseensus Statement (opposite page). A document drafted by the participants as a policy statement to encourage focus on this area.

•Special Report. A Seminar report providing details of the session results is scheduled for completion in September, 1993 and is available from *AIDS & Society*.

•Special Supplement. This publication is a part of *AIDS & Society*

AIDS in the Global Military

from page 1

ranks. Infections that have the potential to be transmitted through blood or body fluids may pose a risk to other soldiers, especially during conflicts or training exercises. A high prevalance of infection may compromise the safety of the blood supply. In countries with limited medical resources, contaminated equipment, including needles and syringes, may be a source of transmission. By virtue of occupation, soldiers and sailors are at greater risk of injury.

Third, the military is concerned about introduction of new HIV. This may be especially true with military forces with a low incidence of infection, where there may be a need to train and fight alongside military forces with a high incidence and prevalance of HIV infection or to rely on medical support from such countries. This is a sensitive issue, and international policies would need to encompass the concerns of both sides.

Finally, the medical support required to care for individuals who are in later stages of HIV infection is a problem. The military health care system may be compromised and unable to care for difficult long-term infections. This concern, combined with fears of potential transmission, has resulted in policies in some nations to automatically exclude HIV-infected persons from the ranks.

The fact that AIDS is a cross-border, regional issue that forces neighbors to be concerned about infection levels in nearby countries makes the epidemic an explosive issue. In complex ways, the epidemic will play a role in power struggles, in expansionistic thinking, in the calculations of special interest groups. Whether military units are able to carry out their missions and maintain national security will ultimately be determined by readiness in the ranks and stability of the leadership. ❑

—compiled by the editors from notes provided by William Lyerly, Rodger Yeager, Elizabeth Reid and Ben Mbonye.

Editorial

Military HIV: An Opportunity To Recruit

Norman Miller

Policy issues of peace and security are very much linked to the reduction of HIV/AIDS both in national and military populations. To the extent that AIDS undermines civil order and world peace it must be seen as a major threat to human kind. This is true for several reasons.

AIDS recognizes no boundaries and knows no sovereignty. It violates borders with ease as a part of the normal flow of trade and traffic. It may be a part of migratory patterns, refugee movements, military maneuvers and peace-keeping missions. To stem the tide of AIDS demands cooperation across borders and among neighbors, between civilian and military leaders and within military units.

Second, peace and security begin with economic stability and AIDS is a major threat to the economic well-being of many nations. In both civil and military spheres, AIDS is a "hollowing out" process, striking mainly at the 20-40 age group and often taking the more senior officers and high-ranking managers. AIDS reduces the work force in many nations, and disables key bread-winners whose families depend upon them. AIDS will drain savings and reduce monies for investment. AIDS will change the composition of the labor force and reduce production.

Third, military leaders and civilian policy makers are committed to the maintenance of law and order so that nations remain free of aggression and internal strife. To do so necessitates strong military and police forces to keep the peace. If these units become debilitated by AIDS, if the internal peace-keeping forces of a nation are weakened, then the epidemic has struck at the very fabric of law and order.

What will happen when senior officers, highly trained pilots or police commanders become ill in large numbers and must leave the service? What will happen to the morale and discipline in the ranks, to the organization and effectiveness of military units in keeping the peace?

An important policy initiative is to encourage the armies of both western and non-western nations to launch or expand their special campaigns of AIDS prevention within their own military and police ranks, and thereafter to reach out in cooperative ways to civilian groups to address some of the civil-military issues surrounding HIV transmission.

It is possible to envision military personnel, or those who have been recently demobilized, making contributions to AIDS awareness programs as instructors and in some settings, as role-models. Civilian-military cooperative projects are possible; training missions between militaries can be jointly carried out in AIDS prevention. Military personnel can help national leaders reach the youth of their nations with important messages of risk reduction, condom use and AIDS prevention. It is not too late to recruit for major HIV prevention programs. ❑

Report

Berlin Seminar

Donald Burke, Frederic D. Daniell and John Lowe*

The Berlin seminar on HIV/AIDS in military populations was divided into three main sessions (see box). The first a survey of the problem from a military, community and policy perspective. The second a review of the current situation; third a session which looked ahead on issues of care, prevention and policy. The key point:

INTERNATIONAL MILITARY ISSUES—Donald Burke (U.S.A.) suggested military concerns posed by the epidemic fall into four sectors.

• Personnel and manpower losses: HIV has direct effects on military personnel and manpower including the loss of trained soldiers, loss of leaders, and shrinkage of the potential recruit pool.

• Economic burden: The HIV epidemic poses an enormous economic burden to the military, especially military health care systems. The direct costs for health care, replacement and retraining, costs and disability and death payments are substantial. These "reactive" costs can in part be diminished by 'proactive" investments in epidemic control such as education and prevention efforts, screening and early diagnosis, and research. In either case the epidemic represents yet another competing demand for finite resources;

• Military operations: Typically, the importance of any given disease threat is measured by its potential ability to render large numbers of troops in the field unfit for combat. Certain diseases like malaria or diarrhea are well known to be such "war stoppers". However, HIV is not an acute, war-time concern. Safety of the blood supply is the only immediate threat to combat operations posed by HIV.

• National security: As the epidemic erodes the economic well-being of severely affected countries and at the same time saps the military strength and stability, HIV may more correctly be thought of as a potential "war-starter" or a "war-outcome-determinant" rather than a war-stopping disease.

If HIV is a direct concern to the military, why hasn't there been a more concerted effort to date? Clearly, many militaries, and indeed many countries, have been reluctant to admit a problem with HIV/AIDS. Disease among the troops is an important intelligence issue, and military forces are understandably reluctant to reveal their weaknesses. This reluctance is further reinforced by the difficulties inherent in applying rational policy decisions to problems associated with highly personal behaviors such as sexuality.

Military organizations can play an important role in the global fight against the epidemic. In most countries, national military organizations are disciplined populations of young adults. Since military organizations are expert in the education and training of young adults, the military can be an excellent target population for HIV/AIDS education as well. Furthermore, precisely because they are relatively well resourced and influential, military organizations can serve as HIV/AIDS control "demonstration projects" for the country at large. Indeed, military organizations are well positioned to take leadership roles in the fight against HIV/AIDS.

HUMANITARIAN ISSUES—Ian Campbell (Australia), addressed the humanitarian and community concerns posed by the epidemic. The approach he reviewed was developed in Zambia and more recently implemented in several other countries in Africa, Asia, and South America.

An opportunity for positive change: Although HIV/AIDS is a severe problem for many communities, the epidemic can alternatively be seen as an opportunity for growth. It is a development, community, and humanitarian issue in a positive sense. The response to AIDS, if supportive and based on traditional strengths and values, can facilitate a positive process of change in which everyone, including military personnel, can participate. Key elements include health care, community involvement, and capacity for behavior change.

The care process as catalyst: In many developing countries, the community represents stability and strength, whereas other institutions such as the hospital, the health system, the political system have in-built weaknesses. By tying health care in the home to community education and prevention, it is possible to draw upon and foster traditional strengths.

Community agreement and involvement: Inclusive, supportive care can generate energy for involvement, mutual support, and prevention in family members and other infected people. Successful linkage of care to prevention depends on an understanding of how a community forms, and how it makes agreements. The community counselling process consists of community selection, relationship build-

* Author's biographies on page 8.

AGENDA

I HIV/AIDS in Military Populations: Whose Concern Is It?

Chair:	*Norman Miller*
Internal Military Issues	*Donald Burke*
Humanitarian and Community Issues	*Ian Campbell*
Civil-Military Issues	*Ben Mbonye*

II Current Situations, Epidemiology, Programs, Policies

Chair:	*Michael Merson*
Epidemiology of Military HIV/AIDS	*Pricha Singharaj*
Epidemiology of Medico-Legal Issues	*Rafaelle D'Amelio*
Education and Prevention	*Souleymane Mboup*
Policy Issues and Social Issues	*Teresita Bagasao*

III Looking and Planning Ahead: What is Helpful

Chair:	*Elizabeth Reid*
Scenarios, Policies, Lessons Learned	*Rutger Yeager*
Increase Military Prevention Capabilities	*Peter Lamptey*
Care, Prevention, and Treatment	*Amadou Sy*
Future Initiatives	*Eliot Pearlman*

IV Discussion of "Consensus Statement" *Elizabeth Reid*

ing, problem identification (behaviors to be changed), decision making, implementation, and evaluation. Community agreement, like the care process, is complex and often defined in specific terms by the local culture, which includes local views on healing and spiritual beliefs.

Community understanding of behavior change: Behavior change is the fundamental requirement for HIV transmission prevention. Change does not only happen with information or technology from external sources; change can be an internal, community driven process. Affirming the ability of community members to measure their own sexual behavior changes, and to define their own indicators for change, is an important way to help a community sustain behavior change.

The military as a community: Each person in a defined community is also in other communities. Some communities are stable and continuous while others are transient such as those for new recruits. Military communities possess their own unique sets of values and traditions, and these can be sources of strength in dealing with the epidemic.

An opportunity for growth: Through respect for culture, with political support and it is possible to see that while AIDS is everyone's problem, it is also everyone's opportunity for growth.

CIVIL AND MILITARY ISSUES—Ben Mbonye (Uganda), addressed civil military issues from the perspective of his own country.

A multi-sectoral approach is used in Uganda wherein every ministry, including the Ministry of Defense, has an AIDS control program that works closely with numerous national and international organizations with their own control programs. Certain broad policies have been formulated on use of condoms, issues of discrimination against people with AIDS, HIV testing, care of orphans, and others. Policies are being developed regarding legal rights and property ownership, and human resource depletion due to AIDS. Certain other issues are targeted for policy development, but additional education and enlightenment of the public must take place regarding funeral rites, circumcision, and traditional healers.

Regarding military policies and programs, the Ugandan military has nine health education centers funded by the World Bank and USAID that offer counselling and testing for HIV. Patient care is a priority, involving asymptomatic HIV positive patients as well as AIDS patients. Terminally ill patients have the option to retire or to stay. Special programs are available for the care of widows and orphans. The Ugandan Ministry of Defense is a partner in the Uganda Joint Clinical Research Center with the Ministry of Health and the Ministry of Education.

Certain military-specific issues remain unresolved in Uganda. These include: What should the policy be on recruitment of HIV+ persons in to the military? What is the effect of demobolization? Are there dangers to the civilian population, or can these demobilized military personnel be used as a potential cadre of workers to promote HIV/AIDS prevention? Are there differences in the access of medical treatment for military versus civilians, and if so, can these be permitted to continue? What is the appropriate role of the military if civilian strife emerges?

During discussions surrounding knowledge versus beliefs, one participant asked about the value of factual education as a way to effect behavior change. He stated that in many populations a saturation level of knowledge had been reached, and yet behaviors had not been significantly altered.

Voluntary versus involuntary change was also discussed, particularly concerning the lack of success of voluntary behavior change. In countries that are being devastated by the epidemic, where there is little evidence that conventional voluntary programs have been effective, speculation was offered on the value of involuntary (imposed) change.

CURRENT SITUATIONS: PROGRAMS AND POLICIES

Chairperson, Michael Merson (WHO), opened this session with a brief overview of the epidemiology of HIV infection worldwide. Regional trends in the global pandemic were

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- Teresita Bagasao, M.A. (Philippines)
- Bjorn Berdal, M.D. (Norway)
- Hartmut Buchow, M.D. (Germany)
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- Capt. Ian Campbell, M.D. (Australia)
- Peter Chibatamoto (Zimbabwe)
- Col. Myung Kyu Choi, M.D. (Korea)
- Col. Tegos Constantinos, M.D. (Greece)
- Gen. Raffaele D'Amelio, M.D. (Italy)
- Capt. Frederic Daniell, M.D. (USA)
- Appiah Denkyira, M.D. (Ghana)
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- Boubacar Diallo (Senegal)
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- Maj. Josiah Gakuru, M.D. (Kenya)
- Helene Gayle, M.D. (USA)
- Maj. Antonio Silva Grace (Portugal)
- Juan Hernández (Mexico)
- David Heymann, M.D. (WHO)
- Col. Dominique Jaubert, M.D. (France)
- Lars Kallings, M.D. (WHO)
- Peter Lamptey, M.D. (Ghana)
- Lt. Col. B. Laurent, M.D. (Rwanda)
- Col. Yuri Lobzin, D.MSc. (Russia)
- John Lowe (USA)
- William Lyerly, M.P.H. (USA)
- Gen. Ben Mbyone, MBChB, (Uganda)
- Lt. Col. Souleymane Mboup, Pharm.D. (Senegal)
- Michael Merson, M.D. (WHO)
- Norman Miller, Ph.D. (USA)
- Gen. José Moreno, M.D. (Mexico)
- Peter Mugyenyi, MB.CH.B. (Uganda)
- Capt. Ezra Muhumuza, MB.CH.B. (Uganda)
- Maj. Rudolf Nowak, M.D. (Canada)
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- Col. Nurverdi Paktin, M.D. (Turkey)
- Col. Eliot J. Perlman, M.D. (USA/Germany)
- David Puckett (USA/Uganda)
- Elizabeth Reid (UNDP)
- Col. Damanhuri Rosadi, M.D. (Indonesia)
- Commandant Omar Sedrati (Morocco)
- Gen. Pricha Singharaj, M.D. (Thailand)
- El Hadj Amadou Sy (Senegal)
- Gen. Polymenakos Venetsanos (Greece)
- Lt. Col. Raymond Woulens, M.D. (Belgium)
- Rodger Yeager, Ph.D (USA)
- Lt. Konstantin Zhdanov, M.D. (Russia)

were described, with an estimated total of 14 million cases. The expectation is that Southeast Asia will evolve into the area with the largest number of cases. Of the world's 1000 million people aged 15-24 years, 800 million live in the developing world; it is estimated that 6 million are already infected with HIV. This is because 50% of all new infections occur in this age group, the age group which comprises the majority of personnel in most military services.

A description of the epidemic in Thailand by **Pricha Singharaj** outlined the increase in prevalence and incidence of HIV as evaluated by a series of studies from 1985-1993, with an initial increase in rates seen in injecting drug users (IDU) and sex workers in 1988 and 1989. An ongoing study involving military recruits is essential to understanding the epidemiology of HIV in Thailand and has demonstrated a marked regional variation in prevalence, especially in the upper north provinces, where overall rates have been as high as 11% in 21-33 year olds. An evaluation of incidence rates is ongoing.

Several medico-legal issues were discussed by **Raffaele D'Amelio** (Italy), who outlined the HIV screening and testing policies for the military services of the North Atlantic Treaty Organization countries. While several of these Military Services utilize selective screening based on occupation (eg, aviators or health care workers) or on travel histories, only the United States utilizes a required testing program for all personnel. It was pointed out that the military community has a unique opportunity to play a positive role in HIV prevention, delivery of care and follow-up.

Issues related to education and prevention efforts were outlined by **Souleymane Mboup**, who described the experiences and lessons learned in Senegal. While initial studies have found prevalence rates for HIV of 0.6% in selected military populations, the rate in certain populations of female sex workers has been 11.7%. An initial survey of military personnel has indicated that 87.1% have received education and 66% reported utilizing condoms regularly. This knowledge, attitudes and practices survey is part of a military-wide combined HIV and STD prevention program begun in 1991, which has benefited from a high level of command support and utilizes an information campaign, workshops and other outreach activities, and condom distribution.

A presentation on policy and social issues by **Teresita Bagasao** focussed on two major points. First, the military draws people from the civilian sector, and empowerment of these individuals can assist in modifying behavior in both groups. Second, there may be a number of areas where the military and the community can work together on joint prevention activities. At the end of this session, a question and answer period focussed on several issues related to non-compulsory testing raised by **Dominique Jaubert** (France) and **Raymond Wouters** (Belgium). **Yuri Lobzin** (Russia) covered several points on risk factors based on experiences gained in his own country.

Michael Merson concluded the session by summarizing that the age groups in military services are at risk, that military programs may be able to demonstrate which approaches to prevention are effective, and that there are a number of areas where concurrence is not possible that are related to military-specific issues or to issues where military policies interact with the civilian sector.

LOOKING AND PLANNING AHEAD—Chairperson Elizabeth Reid (UNDP), suggested there was a role emerging within the militaries of the world, one of care and care of others in bringing about the matter of behavioral change in the campaign against HIV/AIDS.

SCENARIOS, POLICIES AND LESSONS LEARNED—Rodger Yeager (USA). The focus of this session is the public policy implications of HIV/AIDS in relation to the interactions of military forces with their societies. The task at hand is to agree upon a plan to confront this major public health problem with a workable public policy. Success will be measured in terms of the policies' effectiveness.

AIDS is a compelling public policy problem and a highly controversial political issue. These two attributes of the pandemic are present throughout the world in two different specific contexts, affecting both mission oriented institutions, such as military organizations, and society. They create a dilemma of choice but also present two interesting opportunities for response. First, to find ways to convert the problem from a politically disabling public health issue into a multifaceted problem solving opportunity. Second, to transform these opportunities into positive actions of key policy makers at all levels inside and outside the military establishment. To the extent this can be accomplished, the problem can then be subjected to collaborative problem solving activities.

INCREASING MILITARY CAPABILITIES IN THE FACE OF HIV/AIDS—Peter Lamptey (Ghana/USA) stated military populations are at high risk of acquiring HIV in most countries. Military institutions have a unique opportunity to develop a comprehensive HIV prevention program that includes behavior change, access to condoms, control of STD's, and evaluation of HIV prevention programs. For these interventions to occur, however, military leadership must establish supportive AIDS prevention policies. These policies must define the political and fiscal commitment of the nation and address the status of HIV positive individuals within the military.

CARE AND PREVENTION: ISSUES FOR MILITARY PERSONNEL, DEPENDENTS AND COMMUNITIES—Amadou SY (Senegal). The military should not be considered a separate community, but seen as a part of its national culture. Therefore, the link to civilian community is always potentially present. The military builds roads, schools, and other civilian projects. In some countries many patients in military hospitals are civilians. Interaction with civilians and the military is very strong. The capabilities of the military establishment have placed it in a significant role in the planning process for the provision of care, prevention and treatment of HIV/AIDS.

In planning for care in the face of HIV/AIDS it is essential to consider that care will be provided by a group of men and women in their most active and most productive years. They have the same cultural, social and economic needs and have the same norms as the military. The military traditionally reflects all important norms of the country. ❑

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